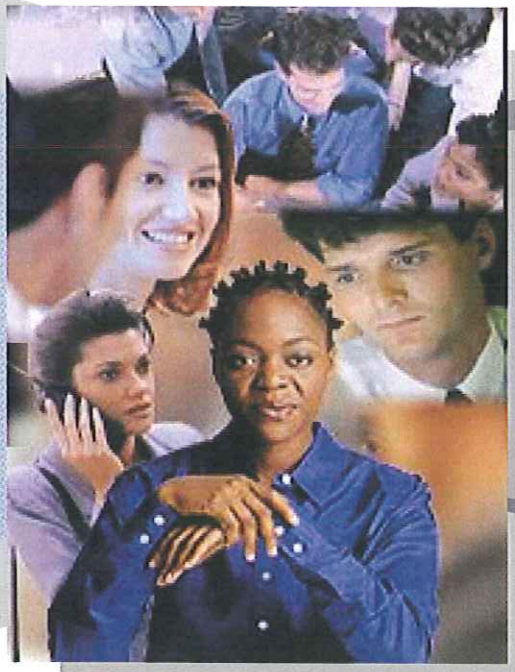
Washington Health Care Authority
Department of Social & Health Services

Washington State
Transitional Bridge Demonstration

Section 1115 Annual Report

Demonstration Year 1: 1/1/11 – 12/31/11
Demonstration Year 2: 1/1/12 – 3/31/12



2011 - 2013

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

April 25, 2012

Ms. Cindy Mann, Director
Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Mail Stop S2-26-12
Baltimore, MD 21244-1850

Dear Ms. Mann:

Without a doubt, Washington State's Transitional Bridge 1115 Demonstration has been essential to sustain coverage for three populations for whom there were no other affordable coverage options. Average enrollment over the course of the first Demonstration Year, January 1, 2011 – December 31, 2011 was:

- Basic Health – 37,185.
- Medical Care Services (Disability Lifeline) – 16,070.
- Medical Care Services (ADATSA) – 4,177.

This report summarizes key milestones, operational challenges, and lessons learned through the first quarter of the second Demonstration Year. During this time Transitional Bridge programs survived two legislative sessions and four special legislative sessions in which many options were actively debated for cutting or eliminating one or all programs. As of April 11, 2012, the end of the latest special legislative session, the 2012 Supplemental Budget maintains all Transitional Bridge programs intact.

Our focus can now turn to detailed planning for the transition to 2014, when most Transitional Bridge program enrollees will be eligible for Medicaid or Exchange coverage. Our goal is to automate the transition as seamlessly as possible. A preliminary random assessment of current enrollees suggests that most could transfer directly to newly-eligible MAGI-Medicaid coverage beginning January 1, 2014. The transition to 2014 is also being informed by recent planning to close out Transitional Bridge programs, contemplated in response to active legislative debate.

Technical assistance from CMS staff was immensely helpful in identifying and resolving potential issues early on in this process. The agency hopes to apply much of that learning to the Transition plan required by CMS in July 2012.

Per our current Special Terms and Conditions agreement, Jenny Hamilton continues to serve as the point of contact for questions on the Demonstration. She can be reached at (360) 725-1101 or via email at jenny.hamilton@hca.wa.gov.

Sincerely,

Doug Porter
Director

Enclosure

cc: Preston Cody, Assistant Director, Health Care Services, Health Care Authority
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Nathan Johnson, Medicaid Policy Manager, Health Care Policy, Health Care Authority
Carol Peverly, CMS Regional Office

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A. Demonstration Description:

Through the early Medicaid expansion option provided in the Patient Protection and Affordability Act (ACA) Section 1902(k)(2), Washington's Transitional Bridge Demonstration waiver uses Medicaid (Title XIX) matching dollars to help sustain the Basic Health and Medical Care Services (Disability Lifeline and ADATSA) programs. Assuming continued appropriation of state funds to support the programs, the Demonstration supports 2 key goals.

- Maintain coverage for low-income individuals enrolled in the Basic Health and Medical Care Services (Disability Lifeline and ADATSA) programs until the full expansion of the Medicaid program takes effect in 2014[1]. (*At that time, individuals with family incomes up to 133 percent of the federal poverty level (FPL) will be covered under the Medicaid State plan. Currently these individuals are under age 65, not-pregnant, and not otherwise eligible for Medicaid and Supplement Security Income*.)

- Use the Transitional Bridge programs as a dynamic early-learning laboratory to (a) identify and resolve issues in preparation for implementing the ACA Medicaid expansion in 2014, and (b) inform federal and state policy makers about program attributes that are consistent with ACA policy goals and provisions and could be considered for new Medicaid expansion and currently Medicaid-eligible populations.

B. State Contacts:

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[1] As a result of the fiscal crisis, recent budgets sought to eliminate one or all Transitional Bridge waiver programs.As of April 11, 2012, the 2012 Supplemental Budget maintains programs intact.

C. Demonstration Progress:

This report provides a comprehensive record of progress on the Transitional Bridge Demonstration during its first full year and the first quarter of the second Demonstration year. It covers the period January 1, 2011 – March 31, 2012, and includes the status of milestones, enrollment, the impacts of legislative action, operational challenges and lessons learned, and an overview of budget neutrality. It summarizes regular CMS monitoring calls, with technical assistance requests and implementation issues noted where applicable.

1. Milestone Expectations

The Transitional Bridge Demonstration was approved and became effective January 2011 with an expectation that it would offer a dynamic platform to transition towards national health reform in 2014. Periodic milestones occur over the course of the demonstration and have been included as explicit requirements of the Special Terms and Conditions. Milestones are listed below with a brief description of their current status. Those completed are shaded; those completed within the last 6 months are shaded in blue.

MILESTONES	STATUS
2011:	
Citizenship determination based on data matching through the social security verification system.	Process was tested and successfully applied to verify citizenship for existing Basic Health enrollees. Future use tied to outcome of litigation described in section 3, Operational Challenges.
Elimination of MCS time limits (i.e., maximum eligibility period of 24 months in a 5 year period).	Completed. Although implemented prior to Transitional Bridge approval, time limits were reversed in response to litigation and to meet CMS' STCs.
Screening of new BH applicants and enrolled BH members (during recertification) for Medicaid eligibility and enrollment.	Implemented. Recertification update provided in Appendix A.
Income determination for identification of BH and MCS individuals eligible for federal match claim based on the Family Medicaid (TANF) methodology as allowed in the CMS guidance letter of April 9, 2010.	Implemented. This is key to determination of Transition Eligible status.
Rollback of monthly premium cost sharing to 2009 levels for the lowest income BH enrollees (i.e., individuals with family income from 0-65 percent of the FPL)	Implemented. Effective 1/1/11 premium contributions for Basic Health enrollees in income band A reduced from $34 to $17 for the duration of the demonstration.
Exemption of American Indian/Alaska Natives from premium and point-of-service cost sharing in Basic Health.	Implemented. Payments made in August 2011, retroactive to 1/1/11.
Equitable approach to managing the Basic Health waiting list given priority designation of sponsored AI/ANs and potential impact of eliminating Tribal cost sharing.	
Mental health parity for Basic Health.	Statutory and regulatory changes completed
No cost sharing for preventive care.	Implemented 1/1/11

MILESTONES	STATUS
Elimination of pre-existing condition waiting period for BH children (limited numbers).	Implemented 1/1/11
No reduction in Basic Health benefits; MCS benefits changes tied only to changes in the State Plan.	Basic Health benefits unchanged. State Plan amendments (SPA) directed by supplemental budgets incorporated in MCS. The plan to stop paying for emergency-room visits for all conditions deemed "non-emergency" was suspended by Governor Gregoire. A budget compromise was agreed to by hospitals, emergency room doctors, and the HCA. It pursues emergency room savings through the use of best practices and feedback reports.
Fair hearings for Basic Health (denials of service) processed through Medicaid systems once the formal Independent Review Organization (IRO) process is exhausted.	Implemented. Washington Administrative Code (WAC) became effective 8/8/11 after final rules filing of 7/8/11. The Basic Health Certificate of coverage was updated and member alert developed to acknowledge new rules. Details available at: www.hca.wa.gov/documents/laws/basichealth/11-01-final.pdf
Fair hearings for Basic Health (denials of eligibility)	Implemented a fair hearing process for subsidized Basic Health applicants and recipients effective February 13, 2012.
Managed care contract revisions to comply with requirements of 42 CFR Part 438 as necessary	New Basic Health contracts executed effective July 1, 2011. Medical Care Services – Disability Lifeline contract delayed (see Section 3, Operational Challenges). Revised contract now executed effective July 1, 2011.
Systems and processes in place to claim for federal match	Implemented for all 3 demonstration groups.
Administrative and information system challenges and enhancements identified (if any) to:	
• track out-of-pocket charges and determine 5% aggregate cost sharing cap for low income population coverage options in 2014;	Originally anticipated as a component of cost-sharing discussions related to the proposal submitted to CMMI by Governor Gregoire (April 29, 2011) for the authority to implement "Health Innovations for Washington". Now being incorporated in systems planning for the Health Benefits Exchange and Medicaid expansion.
• ensure that no federal financing support is claimed for services provided in Institutions for Mental Disease (IMDs) – currently this is approximately 2% of expenditures for the MCS program, 0% for BH; and	Will be incorporated in end of year processing by the HCA's actuarial consultant. Tested during development of the waiver application.
• allow a smooth interface among coverage options that support low income populations. Manual administrative controls may initially be necessary, with automated processes developed over time to meet PPACA compliance in 2014.	Administrative processes were modified to enhance transitions between Basic Health and Medicaid programs. Discussions with stakeholders resulted in provision of scenarios that will be used to inform transition processing in preparation for the Medicaid expansion in 2014. Planning for 2014 transition is underway. Details available at: http://www.hca.wa.gov/hcr/me/
2012:	
Competitive purchasing efficiencies including joint BH/Medicaid procurement (with	2012 managed care procurement progressing with efficiencies anticipated and apparent in rates. Contracts awarded to 5

MILESTONES	STATUS
standardized quality and performance measures, application streamlining, common Basic Health/Medicaid managed care delivery system) and delivery system streamlining to fully support mental health parity for all MCS enrollees.	Apparent Successful Bidders. Readiness review underway (March 1 – May 31, 2012). Service area maps for July 1, 2012 are available in Appendix B – Joint Procurement – Proposed managed Care Program Service Areas. Details available at: http://www.hca.wa.gov/procurement.html See section 3, Operational Challenges – timing/impact of 2011 Legislative action and ongoing budget uncertainty resulted in the exclusion of MCS-DL from the 2012 joint procurement. A single MCO (CHPW) will continue to support the program for the foreseeable future.
Methodology implemented for determining and capturing demographic data to identify American Indian/Alaskan Native (AI/AN) tribal membership. This will inform the potential interface requirements among coverage options for low income populations in 2014 to support cost sharing restrictions for AI/AN individuals.	As of 3/31/12, there are 890 Tribal members enrolled in Basic Health through 10 Sponsorship Tribes. Under their agreement with the HCA, Tribal Sponsors are required to obtain and maintain documentation of eligible native status for individuals they sponsor. Exemption from cost-sharing is established in managed care contracts effective 1/1/11. Additionally the HCA is working through the American Indian Health Commission (AIHC) to develop processes for the identifying other eligible American Indian/Alaska Native populations. See section 3, Operational Challenges and Appendix D (a letter from the AIHC to the HCA).
Elimination of pre-existing condition waiting period for BH adults.	Incorporated in 2012 contract but effectively implemented earlier given constraints in enrollment.
2013:	
Modified adjusted gross income (MAGI) calculation for Basic Health program eligibility (assuming details known) as an opportunity to work out any administrative challenges prior to PPACA compliance in 2014.	We are involved in numerous Federal/State workgroups discussing how MAGI will be applied.
Cost sharing evaluation findings (and implications) available.	A preliminary Evaluation Plan was included in previous quarterly reports and has been the subject of some discussion with CMS. Further discussion on a more meaningful Evaluation is anticipated in 2012. Stakeholders have expressed concern that the approach to evaluating the Demonstration does not directly apply to its explicit goals. A letter from them was included as Attachment F in the second quarterly report.
Systems expansion to accommodate federal match and adopt encounter rate payments for services provided in Tribal facilities for AI/ANs covered under capitated contracts.	Requires further discussion based on implementation of methodology for identifying and tracking AI/AN status. Conversations to raise awareness and understand potential timing of systems changes continue. Changes to track AI/AN status for key Medicaid information systems are underway.
2014:	
Prepared to adopt PPACA requirements for Medicaid. Preliminary Transition Plan required July 2012 for CMS review.	Transition planning is underway for all Medicaid optional programs in addition to the Transitional Bridge waiver programs. A very high-level overview has been discussed with CMS and is described in section E – Transition Plan.
Single contract (to be considered if state Basic Health option offers best continuity of coverage/cliff avoidance for 133-200% FPL individuals).	For future discussion.

2. Enrollment

Quarterly and annual average (rolling) caseloads and corresponding Transition Eligible enrollment in the Basic Health and Medical Care Services (Disability Lifeline and ADATSA) programs are summarized in the following table. Monthly rolling counts for actual and projected enrollment are included with section 4 details on budget neutrality.

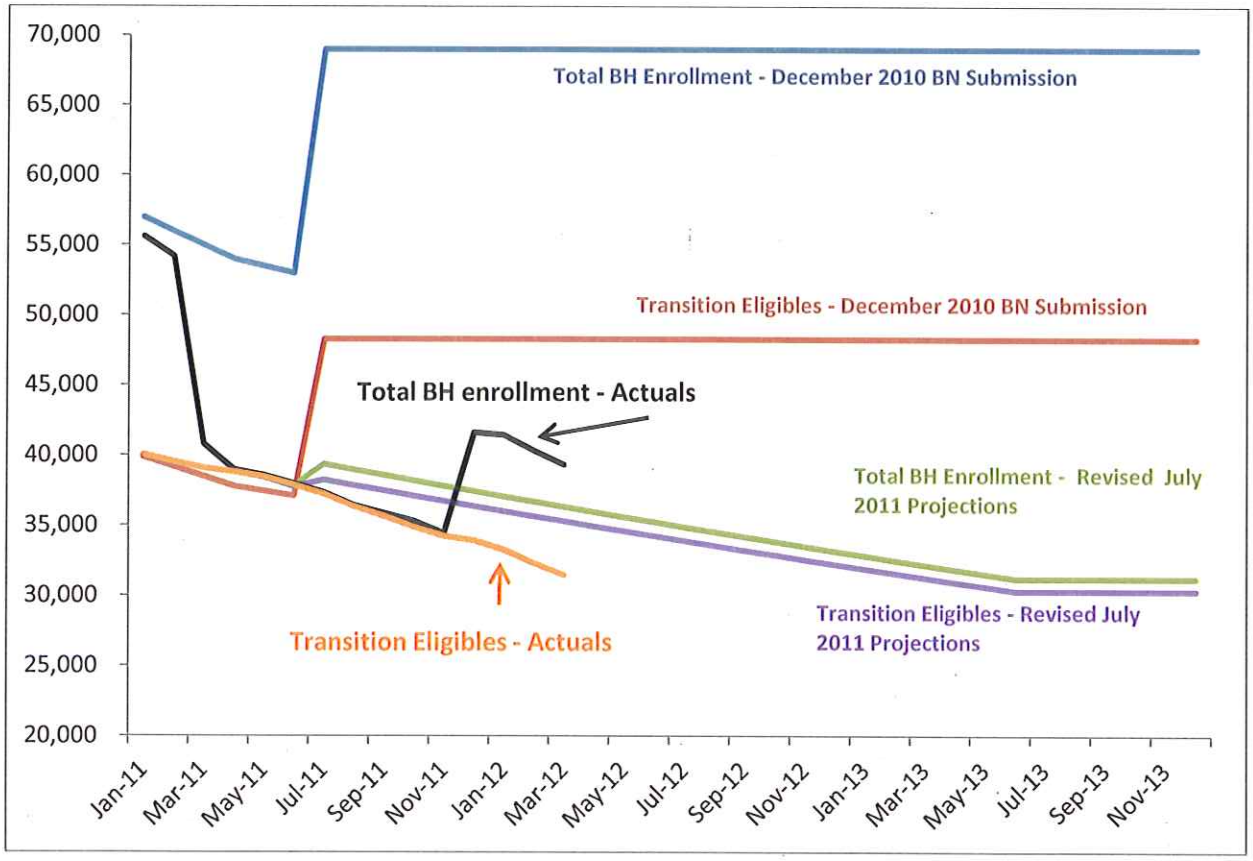
Demonstration Group	STC Annual Average Transition Eligibles	Average Program Caseload	Average Transition Eligibles
Basic Health	43,300	**Rolling quarterly averages:** Q1 (1/1/11 – 3/31/11) 50,197 Q2 (4/1/11 – 6/30/11) 38,515 Q3 (7/1/11 – 9/30/11) 36,558 Q4 (10/1/11 – 12/30/11) 37,138	**Rolling quarterly averages:** Q1 (1/1/11 – 3/31/11) 39,568 Q2 (4/1/11 – 6/30/11) 38,395 Q3 (7/1/11 – 9/30/11) 36,425 Q4 (10/1/11 – 12/30/11) 34,354
		Annual average: DY1 (1/1/11 – 12/30/11) 40,602	**Annual average:** DY1 (1/1/11 – 12/30/11) 37,185
Medical Care Services (Disability Lifeline)	16,000	**Rolling quarterly averages:** Q1 (1/1/11 – 3/31/11) 17,706 Q2 (4/1/11 – 6/30/11) 17,163 Q3 (7/1/11 – 9/30/11) 16,823 Q4 (10/1/11 – 12/30/11) 13,995	**Rolling quarterly averages:** Q1 (1/1/11 – 3/31/11) 17,328 Q2 (4/1/11 – 6/30/11) 16,807 Q3 (7/1/11 – 9/30/11) 16,459 Q4 (10/1/11 – 12/30/11) 13,688
		Annual average: DY1 (1/1/11 – 12/30/11) 16,422	**Annual average:** DY1 (1/1/11 – 12/30/11) 16,070
Medical Care Services (ADATSA)	4,000	**Rolling quarterly averages:** Q1 (1/1/11 – 3/31/11) 4,218 Q2 (4/1/11 – 6/30/11) 4,211 Q3 (7/1/11 – 9/30/11) 4,132 Q4 (10/1/11 – 12/30/11) 4,179	**Rolling quarterly averages:** Q1 (1/1/11 – 3/31/11) 4,214 Q2 (4/1/11 – 6/30/11) 4,204 Q3 (7/1/11 – 9/30/11) 4,123 Q4 (10/1/11 – 12/30/11) 4,169
		Annual average: DY1 (1/1/11 – 12/30/11) 4,185	**Annual average:** DY1 (1/1/11 – 12/30/11) 4,177

Demonstration Group Overview:
Over the first Demonstration year Washington operated under a continuing fiscal cloud with action by the Legislature influencing total enrollment in Demonstration programs. Eligibility parameters for individuals who are "transition eligible" did not change, but total enrollment declined in the Basic Health (BH) and Medical Care Services – Disability Lifeline (MCS-DL) programs. ADATSA has remained consistent with original enrollment projections.

The following describes the current status of enrollment for each demonstration group, with references to interventions that have impacted enrollment since implementation of the Transitional Bridge demonstration in January 2011. Charts show current enrollment alongside projections from the original budget neutrality submission and official revised projections that followed 2011 Legislative action.

- The original basis for BH enrollment projections was the state fiscal year (SFY) 2010 supplemental budget executed May 5, 2010. It assumed that Washington would be successful in obtaining the Transitional Bridge demonstration waiver with allowance for federal financial participation (FFP) to sustain the program at an enrollment maximum of 69,000 by June 2011.
- The 2011 early action supplemental budget (HB 3225) assumed that BH enrollment would be managed through the remainder of SFY 2011 with a decline in subsidized enrollment to 52,000 by June 2011.
- The second 2011 supplemental budget (ESHB 1086) restricted BH enrollment to Transition Eligibles (TE) with the assumption that coverage for non-TEs would be terminated. (Details of subsequent Court proceedings are described in section 3, Operational Challenges, although they do not impact TEs.)
- The 2011-13 biennial budget (2ESHB 1087) continues to limit BH enrollment to Transition Eligibles and assumes a 1 percent attrition rate. Enrollment is expected to average approximately 37,000 enrollees per month during SFY 2012 and 33,000 per month during SFY 2013. New applicants from priority populations were not excluded from enrollment – they primarily include sponsored AI/ANs and individuals who are returning to BH after losing traditional Medicaid eligibility.
- Enrollment in the MCS-DL program appears to be declining after the delinking of health coverage and the prior cash grant. Through E2HB 2082 the 2011 Legislature (first special session) eliminated the original DL program on 10/31/11 and replaced it with 3 new programs effective 11/1/11. Appendix C provides an overview of the new programs and the subsequent enrollment change. Previous Disability Lifeline demonstration populations continue to receive coverage through MCS-DL.
- Although the 2012 Legislature actively debated elimination of Transitional Bridge waiver programs, it ultimately took no action to reduce enrollment.

Basic Health Enrollment Projections (1/1/11 – 12/31/13) and Actuals (1/1/11 – 3/30/12)



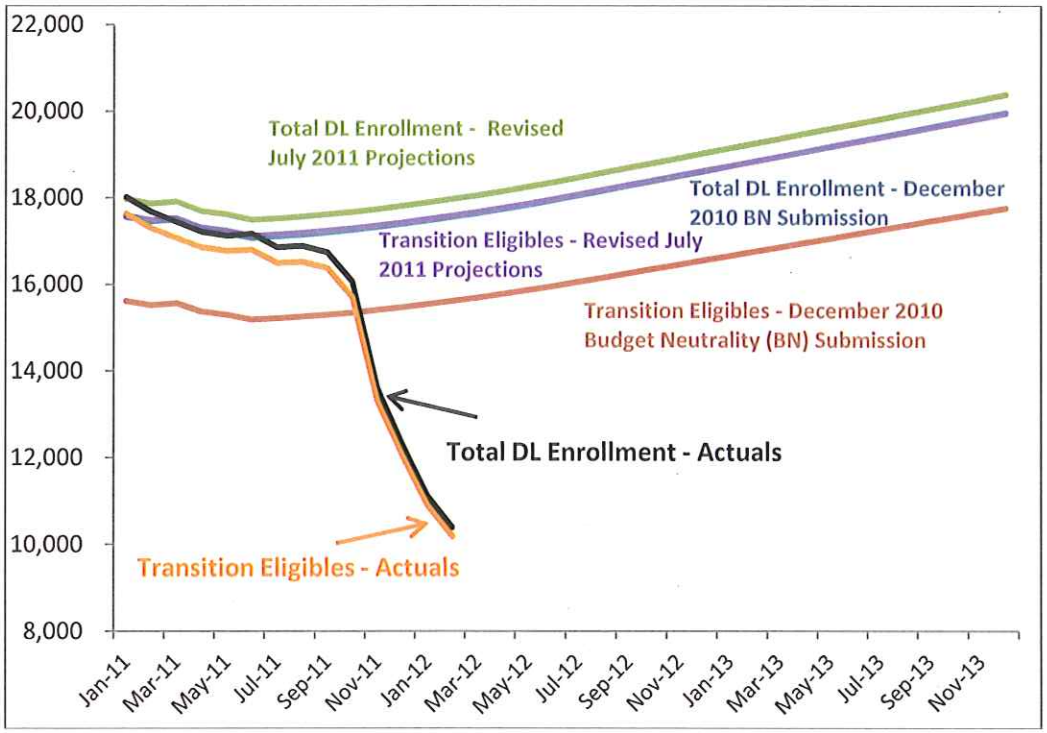
- **Enrollment by Tribal Sponsorship**
  Since the first report, one Tribal sponsor no longer participates in the Basic Health program because its 2 sponsored enrollees left the program. Otherwise, all Tribal sponsors remain and support a stable population of American Indian/Alaska Natives. As of March 2012:

Tribal sponsorship	866
Total subsidized membership	39,309
% of membership Tribal sponsored	2.2%
% of sponsored members that are tribal	9.6%

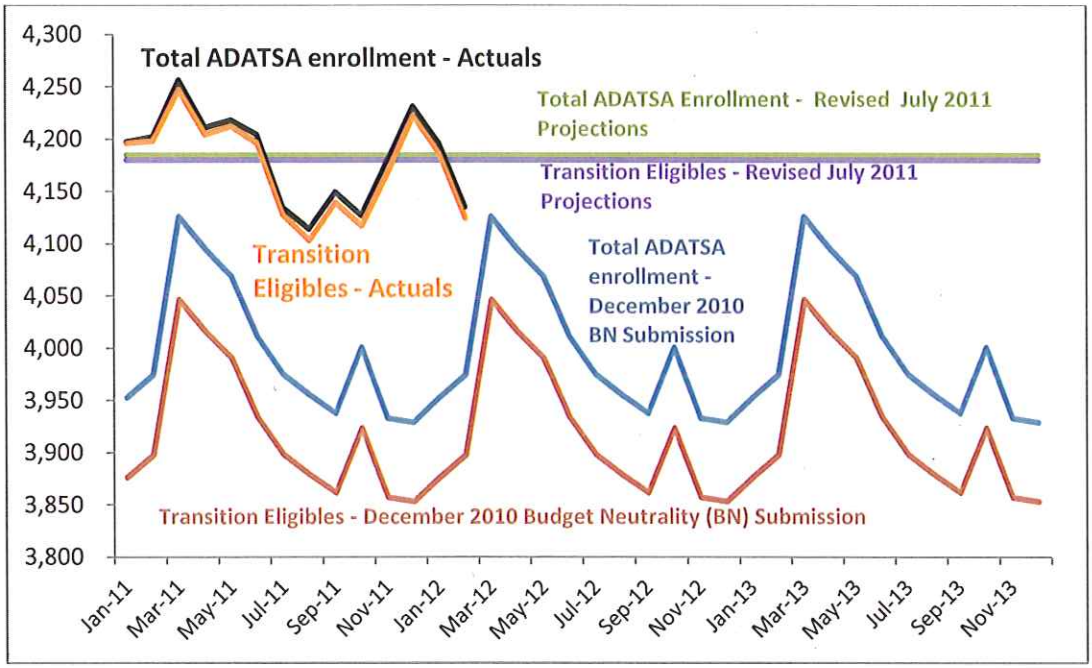
- **Distribution of Basic Health by County and Managed Care Organization (2011 Average)**

County	Community Health Plan of Washington	Columbia United Providers	Group Health Cooperative	Molina Healthcare	Total	% of total
Adams	341	0	0	17	358	0.9%
Asotin	1	0	0	67	68	0.2%
Benton	689	0	0	62	751	1.8%
Chelan	224	0	0	210	434	1.1%
Clallam	0	0	0	825	825	2.0%
Clark	371	2,449	0	0	2820	6.9%
Columbia	2	0	0	41	43	0.1%
Cowlitz	612	0	0	0	612	1.5%
Douglas	100	0	0	94	194	0.5%
Ferry	81	0	0	15	96	0.2%
Franklin	409	0	0	38	447	1.1%
Garfield	0	0	0	22	22	0.1%
Grant	485	0	0	113	598	1.5%
Grays Harbor	519	0	0	226	745	1.8%
Island	415	0	0	0	415	1.0%
Jefferson	424	0	0	0	424	1.0%
King	6667	0	3,496	2	10165	24.7%
Kitsap	569	0	534	1	1104	2.7%
Kittitas	11	0	0	182	193	0.5%
Klickitat	213	0	0	0	213	0.5%
Lewis	330	0	0	172	502	1.2%
Lincoln	0	0	0	93	93	0.2%
Mason	322	0	0	0	322	0.8%
Okanogan	154	0	0	281	435	1.1%
Pacific	42	0	0	139	181	0.4%
Pend Oreille	121	0	0	58	179	0.4%
Pierce	888	0	0	2306	3194	7.8%
San Juan	273	0	0	0	273	0.7%
Skagit	777	0	0	0	777	1.9%
Skamania	75	0	0	0	75	0.2%
Snohomish	1741	0	1,377	0	3118	7.6%
Spokane	1134	0	1,245	1172	3551	8.6%
Stevens	494	0	0	110	604	1.5%
Thurston	602	0	776	140	1518	3.7%
Wahkiakum	59	0	0	0	59	0.1%
Walla Walla	293	0	0	189	482	1.2%
Whatcom	491	0	0	1161	1652	4.0%
Whitman	15	0	0	177	192	0.5%
Yakima	2852	0	0	542	3394	8.3%
Total of avg's	22,796	2,449	7,428	**8,455**	41,128	
% of Total	55%	6%	18%	21%		

MCS – Disability Lifeline Enrollment Projections (1/1/11 – 12/31/13) and Actuals (1/1/11 – 2/28/12)



MCS – ADATSA Enrollment Projections (1/1/11 – 12/31/13) and Actuals (1/1/11 – 2/28/12)



3. Operational Challenges and Lessons Learned

Implementing and operating the Transitional Bridge at the same time as we navigated two Legislative sessions and four Special sessions has been operationally challenging. Limited resources faced a need to refine complex changes to systems, processes, and managed care contracts, while simultaneously weighing the implications of varying legislative options for meeting budget constraints and STC requirements. For the past 6 months, until the recent supplemental budget was enacted, we were uncertain whether any or all of the Transitional Bridge programs would be eliminated.

Operational Challenges

- The quick-turnaround timing of business activities to respond to Legislative action[2], required disenrollment of Basic Health enrollees who did not meet transition eligibility. This resulted in the filing of a lawsuit in federal district court - Unthanksikun v. Douglas Porter, et al. No. 2:11-cv-00588, US District Court, Western District of Washington at Seattle. On September 28, 2011, a preliminary injunction ordered Basic Health to offer re-enrollment to approximately 11,000 members in two classes; the Equal Protection class and the Due Process class. Details are available at: www.basichealth.hca.wa.gov/. Although the lawsuit does not affect Transition Eligibles, resources continue to be heavily engaged in processing actions required by the Court.

- STCs require that Transition Eligibles enrolled in the Basic Health program *"who have been determined to be American Indians/Alaska Natives"* be exempt from cost sharing. The American Indian Health Commission (AIHC) facilitated a work group to support Washington State's efforts to implement this requirement by:
    a. Clarifying the federal definition of an American Indian/Alaska Native (AI/AN), and
    b. Determining the array of official documents that would support an individual's claim to be an Indian and therefore be exempt from cost sharing.

  Details of workgroup progress were previously included in the first Quarterly Report and subsequently discussed with CMS during monitoring calls.

  Since each Tribe is required to maintain official membership records for individuals they sponsor, we have implemented the cost sharing exemption for AI/ANs whose Basic Health coverage is sponsored. Further implementation and application to preparations for national health reform implementation (e.g., documentation of Indian status for Health Insurance Exchange enrollees) requires CMS acceptance or revision to the AI/AN identification methodology. Suggestions to use the Indian Health Services (IHS) User Letter as confirmation of Tribal status have raised concerns from Washington Tribes. **A letter from the AIHC to this effect is included as Appendix D. We have a common request that consistent workable definitions apply across all publicly subsidized coverage programs**. This will be essential under the ACA of 2014. AI/AN status is not only important for assessing cost-sharing implications to comply with Medicaid and ACA requirements, it is also essential for Tribal facilities to be appropriately reimbursed for the individuals they serve. In rural areas in particular, Tribal facilities are an essential provider for natives and non-natives.

- Prior to the Transitional Bridge waiver, a brief adjudicative proceeding process was in place for denials of Basic Health eligibility. In addition to using the medical assistance program's general hearing rules, Basic Health has now developed a process prior to the scheduling of a hearing to

[2] HB 1544 was described in section 3 - Legislative Action, in the previous quarterly report, page 11.

help provide early resolution to eligibility appeals. To date, this early resolution process has resolved approximately 345 appeals to the members' satisfaction without the need and cost of an evidentiary hearing. The two hearings officers who used to preside over the brief adjudicative proceedings are now the HCA's hearing representative in the fair hearing. HCA provided these employees with training on the hearing process by skilled agency hearing representatives, and worked collaboratively with the Office of Administrative Hearings (OAH)[3] to dedicate resources and staffing to the new case load.

- Medical Care Services- Disability Lifeline operates under a sole-source contract with CHPW (per STCs), based on the Medicaid Healthy Options contract. A preliminary version of the contract was made available for CMS review; however it made little sense to conduct a full assessment until changes to support Legislative action were clarified. This became a moving target, with final legislation not enacted until June 15, 2011 and not fully effective until November 1, 2011. The extent of the changes and the difficulties in establishing revised rates alongside a declining and uncertain fiscal climate further delayed the execution of the revised managed care contract. Although a contract was not finally executed until early in 2012, the effective date coincides with the Transitional Bridge STCs – July 1, 2011. The uncertainty surrounding Legislative action resulted in exclusion of MCS-DL from the Joint Procurement negotiations for 2012. As a result, a waiver revision will now be necessary to continue the sole source arrangement beyond July 1, 2012.

- As reported in the previous quarterly report, criteria for coverage through the Medical Care Services programs may no longer result in expenditures that exceed amounts appropriated in the State's operating budget. Appropriations were based on caseload estimates with no immediate need to implement a wait list. However, management of enrollment, given the uncertainly of the State budget, may require imposition of a waiting list in the future. As a contingency, draft Washington Administrative Code (rules)[4] was filed to operate a waiting list should one be needed. Given the caseload decline described in section 2 – Enrollment, it does not appear that this will be necessary.

Lessons Learned

- While the need, design, and implementation of a demonstration waiver in any state are clearly dependent on factors unique to that state, lessons appear to transfer across states. Following the implementation of Washington's Transitional Bridge, many states contacted us to determine potential application of an 1115 waiver to an early Medicaid expansion in their state. Requests continued following a presentation on the Transitional Bridge at the 2011 NASHP annual conference http://www.nashpconference.org/agenda/2011-sessions/medicaid-waivers-in-the-era-of-federal-health-reform. Inter-state networking is incredibly valuable.

- Monthly monitoring calls with CMS continue to be helpful especially when the fiscal context in Washington state puts the future of the Transitional Bridge in jeopardy. Keeping implementation challenges transparent has allowed federal and state partners to collaborate towards pragmatic resolution of issues. Suggestions made during preliminary planning in

[3] OAH is a separate state agency that employs administrative law judges.

[4] The Draft WAC 182-508-0150 Enrollment cap for medical care services (MCS) – was included in the previous quarterly report.

anticipation of legislative action to eliminate programs can now be applied to the development of the 2014 transition plan – see section E.

- Screening for Medicaid eligibility now occurs annually for all Basic Health enrollees at the time of their coverage recertification. Initially, expertise for this function lay outside the Basic Health program in a separate agency and resulted in a major resource drain. When the two agencies merged effective July 2011, a careful workload review uncovered potential inefficiencies. Before a time-intensive full Medicaid eligibility determination is undertaken, an initial screen now assesses Medicaid characteristics, including minor children in the home and/or disability. Further review does not occur unless characteristics necessary for Medicaid eligibility are present. Unnecessary screenings have now been eliminated.

4. Budget Neutrality

As context for regular budget neutrality progress reporting, the previous quarterly reports recapped details of the Transitional Bridge budget neutrality methodology. Appendix E of this report updates the previous budget neutrality tracking report with caseloads, total expenditures and per-caps presented on a "rolling" basis in. Details include:

Original December 2010 STC details (unchanged since previous report):

- Caseloads for the Basic Health (BH), Medical Care Services – Disability Lifeline (MCS-DL) and MCS-ADATSA programs
- Per-capita costs for BH, MCS-DL and MCS-ADATSA programs
- Budget neutrality total expenditures for BH, MCS-DL and MCS-ADATSA programs

July 2011 estimates based on revised caseload forecasts (unchanged since previous report):

- Revised caseloads for the BH, MCS-DL and MCS-ADATSA programs
- Original per-capita costs for MCS-DL and MCS-ADATSA programs
- Revised Basic Health per-capita costs (explanation follows)
- Budget neutrality total expenditures for BH, MCS-DL and MCS-ADATSA programs

Actual caseloads and expenditures (revised and described further below):

- Actual caseloads for the BH, MCS-DL and MCS-ADATSA programs
- Actual per-capita costs for BH, MCS-DL and MCS-ADATSA programs
- Estimated total expenditures for MCS-DL and MCS-ADATSA programs.

Caseload data:

The reporting of actual caseloads differs across the three programs.

- Basic Health operates under full managed care in which enrollees must pay premiums *prior* to the coverage period. As a result, the State is able to provide accurate monthly enrollment one-month after the service month, with minor adjustments for the impact of subsequent transitions to Medicaid and potential retroactive eligibility. This report covers January 2011 – March 2012.

- Eligibility status is more complex for the Medical Care Services programs because of systems processing and material retroactive eligibility transfers to Medicaid. As a result, enrollment

reflects the fourth month after the service month. This report covers January 2011 – February 2012.

Expenditures:
Washington state expenditures are reported and tracked on an accrual (service month) basis; however there are differences across programs as a result of the delivery system complexities.

- Operating under full managed care normally allows Basic Health per-capita data to be reported (and stable) in the third month after the service month. Previous data reported did not include supplemental payment to managed care plans for the AI/AN population exempt from cost sharing. Current reporting includes adjusted AI/AN payments made following signature of revised managed care contracts. This report covers January 2011 – March 2012.

- Medical Care Services benefits are delivered through a combination of managed care and fee-for-service systems. While managed care payments are made prospectively, they are revised for changes in eligibility. Fee-for-service payments are subject to provider billings, in which providers have up to 12-months to bill for services for a given service month. Therefore, actual (stable) per-capita expenditures will begin to be reported six-months after the service month and will continue to be updated for at least 12-months. This report covers January – October 2011 and clearly indicates a lag in data reporting for ADATSA expenditures.

D. Evaluation Plan

A draft evaluation plan outline was submitted in the previous quarterly report to meet STC requirements. Stakeholders reviewed the plan and submitted a letter with comments and suggestions for modifications. This was included as Appendix F in the previous quarterly report. Subsequent conversations with CMS suggested the need for changes to maximize the evaluation's usefulness for CMS, Washington and other states preparing to implement national health reform. Stakeholders expressed a desire to see the evaluation more closely represent the goals of the Transitional Bridge waiver. At this point it is clear that the goal of sustaining programs would not have been possible without the Transitional Bridge waiver. Of potential interest for further analysis is the decline in enrollment in the Medicaid Care Services - Disability Lifeline program after its delinking from the previously associated cash grant, even though health coverage parameters remained the same. A final evaluation plan will require further discussion with CMS.

E. Transition Plan

STCs require the development of a transition plan by July 1, 2012, for enrollees in Transitional Bridge programs who will transfer to coverage as newly eligible MAGI-Medicaid or Exchange/BHPO enrollees on January 1, 2014.

Preliminary assessment of enrollee information is occurring in conjunction with broader efforts to review transition options for State-funded and optional Medicaid programs – Medically Needy Medicaid for example. A consulting firm, Manatt Health Solutions, is assisting the HCA with analysis. Discussions of preliminary findings and brainstorming of options and issues is being conducted during the week of April 23-27. Conversations include a broad array of stakeholders; Governor's office, Executive branch and Exchange staff; Medicaid expansion IT consultants, and Legislative policy and budget staff. The goal is to

inform system design efforts that will be occurring over the next few months to ensure the maximum flexibility possible in initial system development. While we recognize that not all details will be known to finalize all policy decisions before ACA-eligibility-enrollment-related systems development must begin, we would like to ensure that the capacity to support alternative futures is built into ground floor system design wherever possible.

Key goals for transition planning include:

- Maintain or expand needed services, to the maximum extent possible
- Maximize seamless continuity of coverage from current to future options
- Maximize continuity of coverage among future options
- Leverage state and federal financing to maximize coverage
- Identify and optimize administrative simplification opportunities
- Comply with, or seek waiver from, specific ACA requirements related to coverage and eligibility.

With respect to seamless transitions that avoid interruption in coverage to the maximum extent possible, planning for current enrollees centers on 3 phases of activities:

- **Preparation** - period in which an assessment of enrollee status and statutory authorization determines (a) the extent to which an automated conversion to Medicaid or the Exchange/BHPO (if it is an option) could occur (b) key elements that are currently missing but could be collected in 2012-2013 to increase the automated conversion rate (c) unique sub-populations who are not Transitional-Eligible but statutorily provided coverage through the Basic Health program (e.g., foster parents with gross incomes up to 300% of federal poverty) and (d) potential statutory authorization needed to effect a complete, successful transition.

  An initial assessment is underway. We are considering where collection of additional data is possible and would expand automated conversion potential for childless and other adults (e.g., additional data elements that would optimize automated confirmation of ACA-defined "insurance family", MAGI-income details and AI/AN status.) We recognize that for some, a facilitated conversion approach will be necessary.

- **Transition Period** – period during which enrollees are automatically converted to their appropriate 2014 coverage. We expect this will include an "ex parte like" review to notify current enrollees of their likely 2014 coverage options and the process for providing updated information (through the Exchange portal where possible) and/or appealing the determination.

  Preliminary work conducted when the elimination of the Transitional Bridge waiver programs was being debated by the Legislature is pictured in Appendix F – Transitional Bridge Waiver Demonstration Preliminary Phase-Out Overview. This work provides helpful background to understand the complexities of the transition process and will help identify questions to be answered to plan for a successful conversion.

- **Ongoing Process** – post conversion period in which Transitional Bridge close-out will occur to complete budget neutrality calculations and other accounting/reporting elements in the STCs.

Further work has been ongoing through a federally financed SHAP grant to better understand the availability of providers in the state. Appendix G provides details of a survey of Washington primary care providers conducted in the fall 2011 and includes preliminary analysis of the results. Providers were

asked about their Medicaid book of business and their desire to take on individuals with Medicaid coverage. As in most states, areas with limited primary care provider capacity are predominantly rural.

Appendix A: Basic Health Enrollment Charts

January 2012

Total Member Enrollment Summary					
Enrollment Category	**Child Rated**	**Adult Rated**	**Total**	Previous Month Total	Increase (Decrease)
Basic Health Subsidized Enrollment (1)					
Individual Enrollees	1,803	29,695	**31,498**	32,276	(778)
Provider Sponsor	6	136	**142**	145	(3)
Non-Provider Sponsor	154	4,045	**4,199**	4,264	(65)
Employer Group	2	89	**91**	109	(18)
Foster Parents (FP)		521	**521**	540	(19)
Home Care Workers Family	2	1	**3**	3	0
Total BH Subsidized Enrollment	**1,967**	**34,487**	**36,454**	37,337	(883)
Other BH Coverage					
Home Care Workers Subscribers		78	**78**	80	(2)
S-Medical	8	170	**178**	156	22
BH Plus	11,934		**11,934**	11,941	(7)
Health Coverage Tax Credit (HCTC (3))	70	393	**463**	486	(23)
Washington Health	1,080	5,022	**6,102**	5,894	208
Grand Total BHP Enrollment	**15,059**	**40,150**	**55,209**	55,894	(685)

Basic Health Subsidized Modified Adjusted Gross Income up to 133 percent Federal Income Guidelines of Non-Foster Parent members. BH Age Rating and Income Bands reflect BH's premium determination process for all members.

Gross Family Income (% of FPL) Income Band	**Child Rated**	**Adult Rated**					
	A Age 19 - 25	**B Age 19 - 39**	**C Age 40 - 54**	**D Age 55 - 64**	**Total**	**Income Distribution**	Previous Month's
A Up to 65% FPL	482	4,643	4,454	3,441	**13,020**	35.7%	35.8%
B 65% - 99%	514	2,262	3,256	2,098	**8,130**	22.3%	22.2%
C 100% - 124%	349	1,671	2,672	1,500	**6,192**	17.0%	17.1%
D 125% - 139%	202	953	1,258	546	**2,959**	8.1%	8.1%
E 140% - 154%	186	789	1,124	351	**2,450**	6.7%	6.7%
F 155% - 169%	110	634	770	261	**1,775**	4.9%	4.9%
G 170% - 184%	80	403	537	163	**1,183**	3.2%	3.3%
H 185% - 200%	44	199	310	84	**637**	1.7%	1.7%
I 201% -250% (FP)		26	42	19	**87**	0.24%	0.24%
J 251% -300% (FP)		5	10	6	**21**	0.06%	0.04%
Total	**1,967**	**11,585**	**14,433**	**8,469**	**36,454**	**100.0%**	

Age Band Distribution	5.4%	31.8%	39.6%	23.2%	100.0%
Previous Month's	5.2%	31.9%	39.5%	23.3%	

Female by Age Rating	998	6,907	8,632	5,134	**21,671**
Male by Age Rating	969	4,678	5,801	3,335	**14,783**

Basic Health Subsidized Accounts by Ethnicity	
Ethnicity	**Accounts**
Asian Pacific Islander	1,857
Black / African American	163

Basic Health Subsidized Accounts by Language	
Language	**Accounts**
Korean	453
Russian	513

Wait List Estimated Individuals (4)	
Capture Date	Count
Jun/30/11	150,682
Aug/1/11	152,595

Hispanic Origin	400
Native American	122
White / Caucasian	8,007
Not Reported	17,726
Total Enrollment	**28,275**

Spanish	1,696
Vietnamese	1,208
Other	5,944
Not Reported	18,461
Total	**28,275**

Change	1.3%

January 2011

Total Member Enrollment Summary					
Enrollment Category	**Child Rated**	**Adult Rated**	**Total**	Previous Month Total	Increase (Decrease)
Basic Health Subsidized Enrollment (1)					
Individual Enrollees	3,183	38,675	**41,858**	42,392	(534)
Provider Sponsor	10	296	**306**	320	(14)
Non-Provider Sponsor	404	12,372	**12,776**	13,005	(229)
Employer Group	1	141	**142**	147	(5)
Foster Parents (FP)		530	**530**	528	2
Home Care Workers Family	1	1	**2**	2	0
Total BH Subsidized Enrollment	**3,599**	**52,015**	**55,614**	56,394	(780)
Other BH Coverage					
Home Care Workers Subscribers		87	**87**	87	0
S-Medical	5	215	**220**	232	(12)
BH Plus	12,727		**12,727**	13,104	(377)
Health Coverage Tax Credit (HCTC (3))	38	288	**326**	303	23
Washington Health	608	3,052	**3,660**	3,187	473
Grand Total BHP Enrollment	**16,977**	**55,657**	**72,634**	73,307	(673)

Basic Health Subsidized Member Distribution by Age Rating and Income Band							
	Child Rated	**Adult Rated**					
Gross Family Income (% of FPL) Income Band	**A Age 0 - 25**	**B Age 0 - 39**	**C Age 40 - 54**	**D Age 55 - 64**	**E Age 65 +**	**Total**	**Income Distribution**
A Up to 65% FPL	921	7,443	6,087	4,538	655	**19,644**	35.3%
B 65% - 99%	889	4,272	4,434	2,593	54	**12,242**	22.0%
C 100% - 124%	683	3,186	3,753	1,961	20	**9,603**	17.3%
D 125% - 139%	365	1,625	1,881	778	8	**4,657**	8.4%
E 140% - 154%	312	1,221	1,595	643	5	**3,776**	6.8%
F 155% - 169%	209	943	1,114	516		**2,782**	5.0%
G 170% - 184%	141	525	733	351		**1,750**	3.1%
H 185% - 200%	79	322	443	204	1	**1,049**	1.9%
I 201% -250% (FP)		24	42	25		**91**	0.16%
J 251% -300% (FP)		7	9	4		**20**	0.04%
Total	**3,599**	**19,568**	**20,091**	**11,613**	**743**	**55,614**	**100.0%**

Age Band Distribution	6.5%	35.2%	36.1%	20.9%	1.3%	100.0%
Previous Month's	6.3%	38.1%	35.5%	18.8%	1.3%	

Female by Age Rating	1,766	12,095	12,018	7,190	462	**33,531**
Male by Age Rating	1,833	7,473	8,073	4,423	281	**22,083**

Basic Health Subsidized Accounts by Ethnicity	
Ethnicity	**Accounts**
Asian Pacific Islander	2,259
Black / African American	190
Hispanic Origin	1,065
Native American	136
White / Caucasian	9,455
Not Reported	28,623
Total Enrollment	**41,728**

Basic Health Subsidized Accounts by Language	
Language	**Accounts**
Korean	645
Russian	655
Spanish	8,043
Vietnamese	1,534
Other	7,717
Not Reported	23,134
Total	**41,728**

Wait List Estimated Individuals (4)	
Capture Date	Count
Nov/30/10	135,570
Jan/3/11	136,784
Change	0.9%

(1) Basic Health Subsidized excludes Home Care Worker Subscribers, S-Medical, BH Plus, HCTC, Washington Health.

* "Child Rated" Beginning January 2011, reflects dependents age 0 - 25.

"Adult Rated" reflects ALL subscribers and spouses regardless of age and disabled dependents over age 25.

(2) Spouses & Dependents of Home Care Workers are counted in the BH Subsidized Category.

(3) HCTC members receiving an advanced credit from the federal program to assist paying monthly premiums.

(4) Estimated number of individuals waiting for coverage based on average members enrolled per account.

Basic Health Recertification Account Details (Calendar Year 2011)

(see table on next page)

Calendar Year 2011 (1/11 - 12/11) Recertification Account Detail

Calendar Year Begins: Jan-11

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Total
RECERTIFICATION SENT													
Assigned ID	0	444	157	233	148	233	213	68	283	466	366	0	2,611
Adhoc/Random	0	2,192	1,727	2,550	2,356	2,812	1,044	1,189	3,983	3,034	2,715	0	23,602
TOTAL REQUESTS SENT	0	2,636	1,884	2,783	2,504	3,045	1,257	1,257	4,266	3,500	3,081	0	26,213
RECERTIFICATION COMPLETED													
Certified (Responded & Subsidy Eligible)	21	1,490	1,381	2,003	1,821	2,150	1,110	974	2,221	2,303	1,178	19	16,671
Pended - At End of Cycle	0	82	110	173	147	248	13	75	1,357	300	1,361	0	3,866
1. Disenrolled - Ineligible for Subsidized BH - (Including Over 200% FIG)	0	40	31	49	36	64	27	23	42	62	23	0	397
2. Disenrolled - Voluntarily	2	539	124	97	81	103	56	46	151	173	63	0	1,435
3. Disenrolled - No Response to Recertification - Transferred out of subsidized	2	451	284	477	453	537	139	193	511	659	494	0	4,200
4. Total Accounts Disenrolled (1,2,& 3)	4	1,030	439	623	570	704	222	262	704	894	580	0	6,032
Total Accounts Completions	25	2,602	1,930	2,799	2,538	3,102	1,345	1,311	4,282	3,497	3,119	19	26,569
Other Accounts (Removed From	-25	34	-46	-16	-34	-57	-88	-54	-16	3	-38	-19	-356
TOTAL ACCOUNTS	0	2,636	1,884	2,783	2,504	3,045	1,257	1,257	4,266	3,500	3,081	0	26,213
PERCENTAGE													
5. % Certified	84.0%	57.3%	71.6%	71.6%	71.7%	69.3%	82.5%	74.3%	51.9%	65.9%	37.8%	100.0%	69.8%
6. % Pended At The End of Cycle**	0.0%	3.2%	5.7%	6.2%	5.8%	8.0%	1.0%	5.7%	31.7%	8.6%	43.6%	0.0%	10.0%
7. % Responded - Not Certified (1,2)	8.0%	22.3%	8.0%	5.2%	4.6%	5.4%	6.2%	5.3%	4.5%	6.7%	2.8%	0.0%	6.6%
8. % No Responded, Transferred Out of Subsidized (3 only)	8.0%	17.3%	14.7%	17.0%	17.8%	17.3%	10.3%	14.7%	11.9%	18.8%	15.8%	0.0%	13.7%
9. % Accounts Disenrolled	16.0%	39.6%	22.7%	22.3%	22.5%	22.7%	16.5%	20.0%	16.4%	25.6%	18.6%	0.0%	20.2%
TOTAL (5,6,7, & 8)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

*Each column represents the total number of accounts selected and completed recertification by cycle.
*Accounts selected in a month complete the process 90 days later.

**Percent Pended At End of Cycle are response received and not processed before cycle completion. System automatically remove accounts to prevent unwarranted disenrollment. Accounts with non-processed mail at the end of the cycle are also automatically

*No Self Employed income were reported for January - February 2005; however Self Employed Income was reported for March 2005 which are included totals.

*No data to report on for DOR Income Mismatch and ESD Income Mismatch for FY05 Recertification Send Selection.
* No accounts were selected for recertification in January 2011.

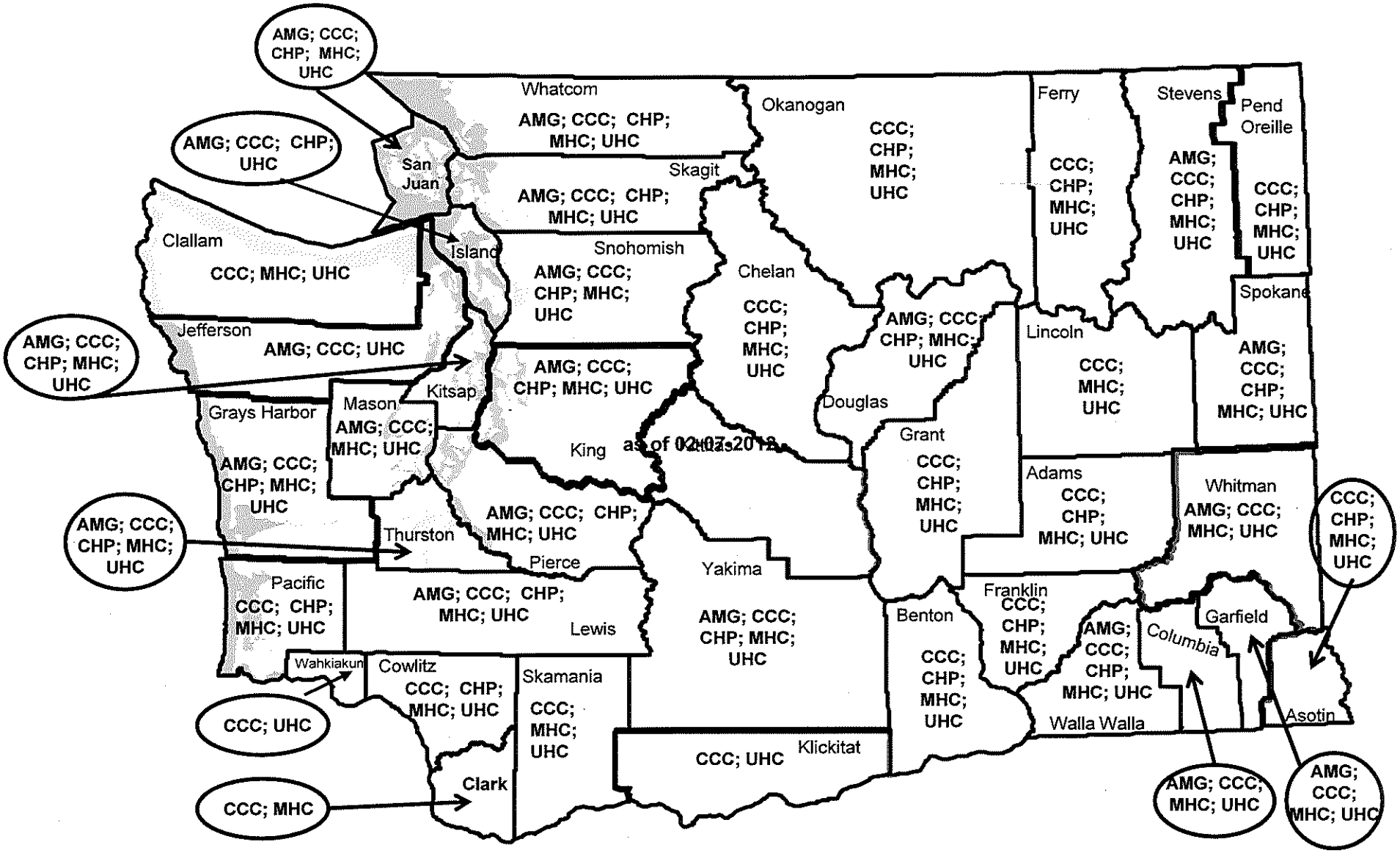
Appendix B: Joint Procurement – Proposed Managed Care Program Service Areas

2012 Basic Health Coverage Summary (Prior to 7/1/12)

County	Community Health Plan of Washington	Columbia United Providers	Group Health Cooperative	Molina
Adams	X			X
Asotin	X			X
Benton	X			X
Chelan	X			X
Clallam				X
Clark	X	X		
Columbia	X			X
Cowlitz	X			
Douglas	X			X
Ferry	X			X
Franklin	X			X
Garfield				X
Grant	X			X
Grays Harbor	X			X
Island	X			
Jefferson	X			
King	X		X	
Kitsap	X		X	
Kittitas	X			X
Klickitat	X			
Lewis	X			X
Lincoln				X
Mason	X			
Okanogan	X			X
Pacific	X			X
Pend Oreille	X			X
Pierce	X			X
San Juan	X			
Skagit	X			
Skamania	X			
Snohomish	X		X	
Spokane	X		X	X
Stevens	X			X
Thurston	X		X	X
Wahkiakum	X			
Walla Walla	X			X
Whatcom	X			X
Whitman	X			X
Yakima	X			X

Proposed Managed Care Program Service Areas

Effective 7-1-2012

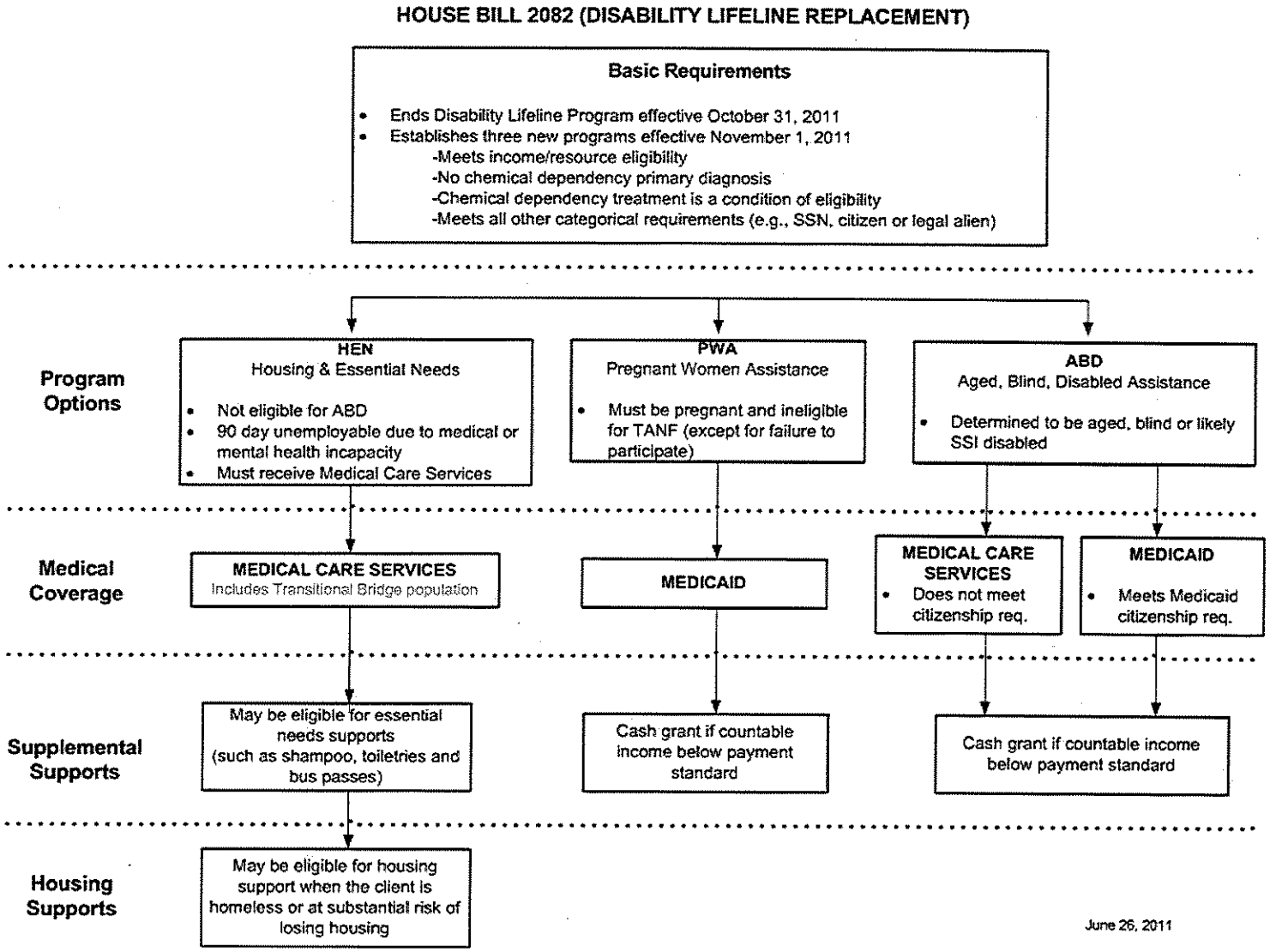


AMG; CCC;
CHP; MHC; UHC

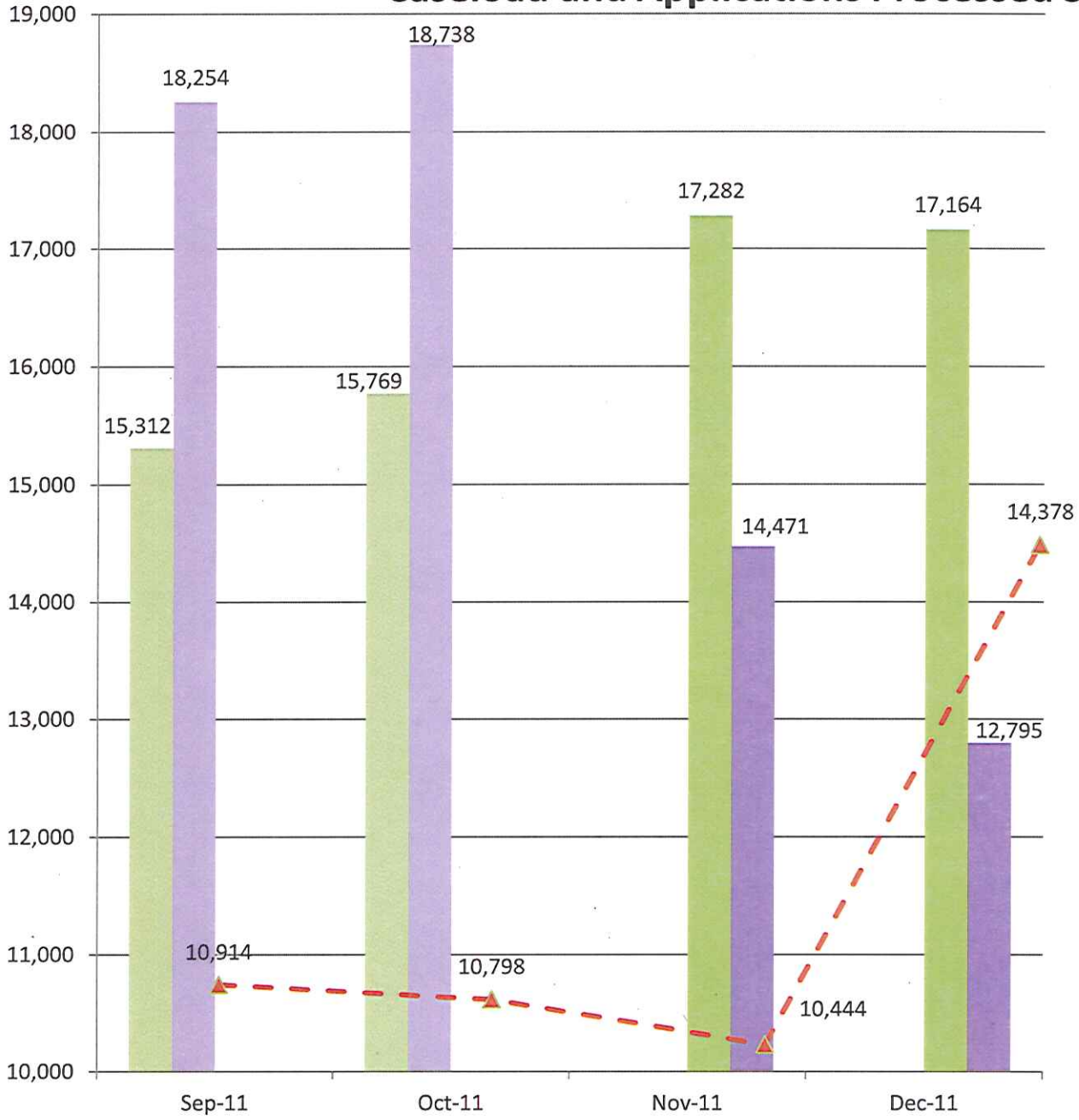
Healthy Options Program
Health Plan Abbreviations

Amerigroup RealSolutions	**AMG**
Coordinated Care Corporation	**CCC**
Community Health Plan of Washington	**CHP**
Molina Healthcare of Washington, Inc.	**MHC**
United Healthcare Community Plan	**UHC**

Appendix C: Disability Lifeline Replace Overview and Caseload Summary



Incapacity & Disability Programs
Caseload and Applications Processed Summary



Notes

*Source: eMAPS 1/30/2012.

*December numbers are based on first run data and therefore may change.

*Applications processed data reflects the date the application was approved or denied and does not reflect the date the application was submitted.

*The Disability Lifeline program ended 10/31/2011. Clients coded as program type DL-X and DL-Other on or after 11/1/2011 were eligible for the new ABD program. Clients coded as program type DL-U or DL-R on or after 11/1/2011 were potentially eligible for Housing and Essential Needs.

Appendix D: American Indian Health Commission Communications

American Indian Health Commission for Washington State

"Improving Indian Health through Tribal-State Collaboration"

April 14, 2012

Jenny Hamilton
Health Care Authority
P.O. Box 45502
Olympia, Washington 98504-5502

Dear Ms. Hamilton:

This letter is in response to your request for guidance from the American Indian Health Commission (AIHC) on the implementation of Washington's Transitional Bridge waiver provisions that exempt American Indian and Alaska Native (AI/AN) people from cost-sharing requirements. These provisions will exempt AI/enrollees from the Basic Health (BH) program's premium and point-of-service requirements and would also apply to any point-of-service requirements adopted for the Medical Care Services (MSC) program. Both programs are federally financed through the Transitional Bridge waiver.

On behalf of Washington's Tribes and the AIHC, I want to thank the Health Care Authority (HCA) for successfully obtaining the demonstration waiver that allows for federal funding to provide bridge coverage for some 50,000 low-income adults until 2014 when they will be eligible for affordable health coverage through the Medicaid expansion, Washington's health benefits exchange (HBE) and possibly the federal Basic Health (BH) option. This waiver is critically important to our Tribes and urban AI/AN people, as the two programs are providing coverage to some 1,700 AI/AN people. We know that without this waiver, Washington's legislature would have likely had to terminate one or both of these programs.

In accordance with our government-to-government relationship, AHIC members worked with you to develop an AI/AN documentation methodology for the Transitional Bridge wavier (see Enclosure 2). We understand that the Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) has expressed concern about the proposal. Specifically, they want the state to adopt an "IHS users" document.

The AHIC is comfortable with temporarily adopting the documentation methodology prescribed in Enclosure 2. We request that the Transitional Bridge waiver not employ an "IHS User" document at this time. It is our understanding that such a standardized document does not exist. More importantly, the use of such a document may create an

undue burden for AI/AN people residing in urban areas. It also could create an unfunded mandate on tribal programs and other unanticipated impacts on tribal medical programs.

We look forward to continue working with you on waiver issues, as well as necessary policies and procedures for the 2014 Medicaid expansion. If you have any questions about our recommendations, please contact either Sheryl Lowe, AHIC Executive Director, at 360-775-5736 or slowe@aihc-wa.com; or myself at (360) 854-7039 or marilyns@upperskagit.com.

Sincerely,

Marilyn Scott, Chair
American Indian Health Commission

Enclosures

cc:

AIHC Members
Sheryl Lowe
Doug Porter
Debra Sosa
Manning Pellanda
Mary Wood
Nathan Johnson

SUMMARY OF WORKGROUP DISCUSSION – included in Quarterly Report (1-1-11 – 6-30-11)

Introduction

Special Terms and Conditions (STCs) for the Transitional Bridge Demonstration require that individuals enrolled in the Basic Health program "who have been determined to be American Indians/Alaska Natives" be exempt from cost sharing. This is consistent with requirements of the Patient Protection and Affordable Care Act (ACA).

The American Indian Health Commission (AIHC) is facilitating a work group to support Washington state's efforts to implement this requirement. Initial discussions focus on operationalizing the definition of American Indian/Alaska Native (AI/AN) so that individuals to whom the cost sharing exemption applies can be clearly identified and tracked. The following documents the workgroup's progress thus far in:

a. clarifying the federal definition of an American Indian/Alaska Native Indian, and
b. determining the array of official documents that would support an individual's claim to be an Indian.

Implementation of the work group's findings will require approval of the Centers for Medicaid and Medicare Services (CMS) consistent with the STCs.

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a. Definition of American Indian/Alaska Native *Indian*

STCs (i.e., page 12 footnote) use a definition of "Indian" consistent with Section 5006 of the American Recovery and Reinvestment Act (ARRA) and with the ACA. This definition is presented in the following box, with references to current law bolded and relevant excerpts shaded in grey in the text that follows for 42 CFR 136.12, and 25 USC 1603(c), 1603(f), 1679(b).

> Indian means any individual defined at **25 USC 1603(c), 1603(f), or 1679(b)**, or who has been determined eligible as an Indian, pursuant to **42 CFR 136.12**. This means the individual:
> (1) Is a member of a Federally recognized Indian tribe;
> (2) resides in an urban center and meets one or more of the four criteria:
> (a) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
> (b) is an Eskimo or Aleut or other Alaska Native;
> (c) is considered by the Secretary of the Interior to be an Indian for any purpose; or
> (d) is determined to be an Indian under regulations promulgated by the Secretary;
> (3) is considered by the Secretary of the Interior to be an Indian for any purpose; or
> (4) is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

42 CFR 136.12 - Persons to whom services will be provided.

(a) *In general.* Services will be made available, as medically indicated, to persons of Indian descent belonging to the Indian community served by the local facilities and program. Services will also be made available, as medically indicated, to a non-Indian woman pregnant with an eligible Indian's child but only during the period of her pregnancy through postpartum (generally about 6 weeks after delivery). In cases where the woman is not married to the eligible Indian under applicable state or tribal law, paternity must be acknowledged in writing by the Indian or determined by order of a court of competent jurisdiction. The Service will also provide medically indicated services to non-

Indian members of an eligible Indian's household if the medical officer in charge determines that this is necessary to control acute infectious disease or a public health hazard.
(2) Generally, an individual may be regarded as within the scope of the Indian health and medical service program if he/she is regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction.
(b) *Doubtful cases.* (1) In case of doubt as to whether an individual applying for care is within the scope of the program, the medical officer in charge shall obtain from the appropriate BIA officials in the jurisdiction information that is pertinent to his/her determination of the individual's continuing relationship to the Indian population group served by the local program.
(2) If the applicant's condition is such that immediate care and treatment are necessary, services shall be provided pending identification as an Indian beneficiary.
(c) *Priorities when funds, facilities, or personnel are insufficient to provide the indicated volume of services.* Priorities for care and treatment, as among individuals who are within the scope of the program, will be determined on the basis of relative medical need and access to other arrangements for obtaining the necessary care.

Sec. 1603. Definitions

For purposes of this chapter--

(a) ``Secretary'', unless otherwise designated, means the Secretary of Health and Human Services.

(b) ``Service'' means the Indian Health Service.

(c) ``Indians'' or ``Indian'', unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) of this section, except that, for the purpose of sections 1612 and 1613 of this title, such terms shall mean any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary.

(d) ``Indian tribe'' means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(e) ``Tribal organization'' means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

(f) ``Urban Indian'' means any individual who resides in an urban center, as defined in subsection (g) of this section, and who meets one or more of the four criteria in subsection (c)(1) through (4) of this section.

(g) ``Urban center'' means any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under subchapter IV of this chapter, as determined by the Secretary.

(h) ``Urban Indian organization'' means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum

participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of this title.

(i) ``Area office'' means an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

(j) ``Service unit'' means--

(1) an administrative entity within the Indian Health Service,

or

(2) a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act [25 U.S.C. 450f et seq.], through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

(k) ``Health promotion'' includes--

(1) cessation of tobacco smoking,

(2) reduction in the misuse of alcohol and drugs,

(3) improvement of nutrition,

(4) improvement in physical fitness,

(5) family planning,

(6) control of stress, and

(7) pregnancy and infant care (including prevention of fetal alcohol syndrome).

(l) ``Disease prevention'' includes--

(1) immunizations,

(2) control of high blood pressure,

(3) control of sexually transmittable diseases,

(4) prevention and control of diabetes,

(5) control of toxic agents,

(6) occupational safety and health,

(7) accident prevention,

(8) fluoridation of water, and

(9) control of infectious agents.

(m) ``Service area'' means the geographical area served by each area office.

(n) ``Health profession'' means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, an allied health profession, or any other health profession.

(o) ``Substance abuse'' includes inhalant abuse.

(p) ``FAE'' means fetal alcohol effect.

(q) ``FAS'' means fetal alcohol syndrome.

Sec. 1679. Eligibility of California Indians

(a) Report to Congress

(1) In order to provide the Congress with sufficient data to determine which Indians in the State of California should be eligible for health services provided by the Service, the Secretary shall, by no later than the date that is 3 years after November 23, 1988, prepare and submit to the Congress a report which sets forth--

(A) a determination by the Secretary of the number of Indians described in subsection (b)(2) of this section, and the number of Indians described in subsection (b)(3) of this section, who are not members of an Indian tribe recognized by the Federal Government,

(B) the geographic location of such Indians,

(C) the Indian tribes of which such Indians are members,

(D) an assessment of the current health status, and health care needs, of such Indians, and

(E) an assessment of the actual availability and accessibility of alternative resources for the health care of such Indians that such Indians would have to rely on if the Service did not provide for the health care of such Indians.

(2) The report required under paragraph (1) shall be prepared by the Secretary--

(A) in consultation with the Secretary of the Interior, and

(B) with the assistance of the tribal health programs providing services to the Indians described in paragraph (2) or (3) of subsection (b) of this section who are not members of any Indian tribe recognized by the Federal Government.

(b) Eligible Indians

Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:

(1) Any member of a federally recognized Indian tribe.

(2) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant--

(A) is living in California,

(B) is a member of the Indian community served by a local program of the Service, and

(C) is regarded as an Indian by the community in which such descendant lives.

(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

(4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

(c) Scope of eligibility

Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

b. Options for Documenting American Indian/Alaska Native *Indian* Status

To support an application for coverage as an *Indian,* for which an exemption from cost sharing will apply, an applicant must have documentation to confirm Tribal:

a. Membership,
b. Descendancy, or
c. Affiliation.

The following table provides 3 tiers of documents, with tiers representing increasing complexity of documentation requirements. Tier I documents are likely to be the most readily available; tier III may require the assistance of Tribal organizations to locate details.

DOCUMENTS THAT CONFIRM INDIAN STATUS		
TIER I	**TIER II**	**TIER III**
1. Tribal Membership Card with picture from a federally recognized tribe. state recognized tribe or the Bureau of Indian Affairs (BIA) 2. Tribal Sponsorship Agreement with the Health Care Authority for participation in the Basic Health program*	1. Current state driver's license with individual's picture, or a state identity card with individual's picture; AND a. A US American Indian/Alaska Native tribal membership card or tribal enrollment letter, without picture OR b. A certificate of tribal membership / affiliation, OR c. A document issued by the Bureau of Indian Affairs, such as Certificate of Indian Blood, OR d. A document issued by the Indian Health Service (IHS), a Tribal health program or an Urban Indian Program, attesting to an individual's eligibility (as an AI/AN) to receive health services at the IHS or Tribal health facility. ** 2. Indian and Northern Affairs Canada (INAC) Card; AND Documentation of 50% Native blood, such as: a. A Certificate of Indian blood issued by the Bureau of Indian Affairs OR b. A document issued by a federal or state recognized tribe verifying 50% Native blood***	1. Current state driver's license with individual's picture, or a state identity card with individual's picture; AND a. Documentation showing native descent, such as a birth certificate or relative tribal ID cards; OR b. A document issued by the Bureau of Indian Affairs, such as Certificate of Indian Blood. 2. Current state driver's license or state identity card for a non-native mother carrying the child of an eligible native****; AND a. Proof of marriage to an eligible native father who must also provide tier I,II, or III documentation that confirms his AI/AN status; OR b. In cases where the mother is not married to the eligible native father - proof of paternity (in writing), from the father or by order of a court, including a tribal court. The father must also provide tier I, II, or III documentation that confirms his AI/AN status (unless there is a tribal court order).

* Tribal Sponsors are expected to obtain and maintain complete documentation of eligible native status as part of their sponsorship agreement with the Health Care Authority.

** In the state of Washington there are currently 2 Urban Indian Health Centers, 3 Indian Health Service Clinics, and 34 Tribal Health Programs.

*** May be Canadian citizens but remain eligible for Basic Health and zero cost sharing if 50% native blood. The right of American Indians to freely cross the Canadian Border is based on the Jay Treaty signed by the US and Great Britain in 1794. In 1952, the Immigration and Naturalization Act limited the rights of Indians born in Canada to those with at least 50% native blood.

****Non-Native women pregnant with the child of an eligible Native remain eligible for zero cost sharing only during pregnancy and up to six weeks post-partum..